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ORTHOPÆDIC SURGEON TO THE OUT-PATIENT DEPARTMENT OF THE NEW YORK HOSPITAL.

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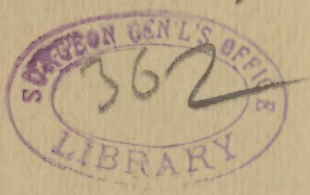

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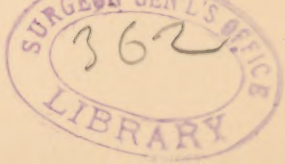
THE QUESTION OF INTERFERING WITH THE ABSCESSES OF HIP DISEASE.*

By A. B. JUDSON, M. D.,

ORTHOPÆDIC SURGEON TO THE OUT-PATIENT DEPARTMENT OF THE NEW YORK HOSPITAL.

(Two cases of hip disease were shown in which abscesses had been absorbed. In one patient, a girl five years of age, the disappearance of a fluctuating tumor of long standing was followed by a dimple in front of and below the great trochanter caused by the contraction of the fascial tissue lying between the integument and the bone. At one time the redness of the skin and the proximity of the pus to the surface led to the belief that the abscess was about to open, but these indications were of short duration. The depression and limited mobility, the latter revealed by palpation and active and passive motion, of a small area was exactly what is found in a scar depressed and attached to fascia, such a scar as follows a discharging sinus, except that the depression was covered by normal skin instead of cicatricial integument. The patient was convalescent, still wearing the hip-crutch without traction, and had been free from symptoms for more than a year. The other patient, a girl eight years of age, came under treatment when three years

* Read before the Orthopædic Section of the New York Academy of Medicine, January 18, 1889.



old. There were nocturnal pain and the usual signs of hip disease. One year later a fluctuating tumor appeared below and in front of the great trochanter, and persisted for a year, the fluctuation extending two inches and a half in a line parallel with the axis of the shaft of the femur. From the beginning the thigh had been enlarged by infiltration of the cellular tissue. About the time the fluctuation appeared the pain ceased and the thigh lessened in circumference, and eight months after its appearance the thighs were equal. Four months later, when it had disappeared, leaving no trace, the thigh was three fourths of an inch smaller than that of the sound side. It is now an inch and a fourth smaller. The coincidence of the cessation of pain and reduction of swelling with the appearance of the fluctuating tumor is explained by the supposition that the pain and inflammation attended the confinement of the pus and ceased when it escaped into the cellular structures. The patient had been free from symptoms for the past three years and a half. Treatment was suspended last spring. These were typical cases of hip disease and exhibited to a moderate degree the asymmetry and disability which generally attend recovery.)

These cases are instructive. They are examples of the favorable result which sometimes follows breaking the time-honored rule that abscesses call for the use of the knife. They may be considered as an offset to two cases which were shown to the Section last May * as examples of the good results of antiseptic incision and scraping.

I regret that I was not present when those cases were shown, because a paper † in which I had presented the advantages of non-interference with the abscesses in question was made the subject of adverse criticism. One of the

* "New York Medical Journal," June 16, 1888, pp. 664, 665.

† *Ibid.*, January 31, 1885, pp. 116–120.

speakers on that occasion, my good friend Dr. Sayre, referred to my views in terms which may have been useful as lending animation to the debate of the evening, but which are of doubtful utility in a scientific discussion. I refer especially to the following words: "It was a disgrace to the orthopædic surgery of America to allow such statements to go abroad uncontradicted." Eloquent invective, such as this, has legitimate and praiseworthy applications in some fields of human effort, but it is quite devoid of meaning in a meeting of medical men gathered to consider questions of theory and practice.

The views which I expressed in 1885 were the result of a number of years of experience and studious observation of cases in dispensary and private practice, and they have been but confirmed by the added experience of the past four years. Such cases as those which I have shown this evening are illustrations of the advantages which sometimes attend withholding the knife. Although, as a rule, the fluctuating tumors of hip disease are followed by purulent eruption, I have seen a number of cases of hip disease and Pott's disease of the spine in which abscesses have disappeared with most favorable results. Observations of this kind are by no means rare in orthopædic practice, as many of us well know. It may be supposed that the water which makes up the bulk of these gatherings is absorbed without difficulty while the residuum coalesces with the cellular tissue, leaving in some cases, like one of those shown to-night, subcutaneous bands of cicatricial tissue, which derange the orderly relations of the normal connective structures. It is not clear why some abscesses are thus absorbed while others approach the surface, perforate the skin, and are evacuated, any more than it is clear why some cases of joint disease are attended with while others are free from abscesses. It is not improbable that many cases which are said to be

free from abscesses have collections of pus limited in quantity and deep in situation which remain quiet and finally disappear without impeding the progress of the case toward recovery. We may, perhaps, look for the reason of this diversity in the individual diathesis rather than in the local peculiarities or accidents of a given case.

Very few, however, of the abscesses of hip disease will thus conveniently disappear, and the question of what to do with them is one of every-day orthopædic practice, and very properly a question for consideration by the members of this section. Although each case as it occurs must be judged by itself, it will be well to recall a few considerations applicable to all cases of the kind. It will, for instance, be generally admitted that in a purulent case of hip disease the abscesses and sinuses are secondary in importance to the condition of the diseased bone from which they spring. They can hardly be considered as adding to the gravity of the case, because destruction of the soft tissues is less serious from every point of view than destruction of the osseous tissue. It is difficult also to see how a purulent sinus can prolong the duration of a case, because its natural tendency is toward cicatrization, an event which is delayed only by the obstinacy of the bone disease. It is also very doubtful, in my opinion, whether abscesses and sinuses hold the relation of cause and effect to visceral degeneration. In the cases of visceral complication which I have seen I have had no reason to question that the disease of the abdominal and thoracic organs has been an expression of a morbid constitution of which the pernicious course of the joint disease is but another expression. Neither will it do to say that the presence of pus forbids the repair of carious bone when cases occur in which recovery is accompanied by the disappearance of abscesses by absorption, and many others in which recovery from the local affection and the resto-

ration of the patient to perfect health are marked by the opening, discharge, and cicatrization of one or more abscesses.

To the general surgeon or to the beginner in orthopædic practice it is difficult to refrain from operating on the abscesses that appear in the progress of a case of hip disease. The traditions of surgery and the expectation of the friends of the patient suggest radical measures and prompt action. There is, however, a notable class of cases in which it is comparatively easy to postpone interference. I refer to those cases in which a single accumulation of pus takes place with a large fluctuating tumor and without pain. The general health of the patient in such cases continues good and he pursues, with the help of the hip splint, the ordinary mode of life. There is an entire absence of symptoms connected with the tumor. There is no urgent call, local or general, for interference. The size of the tumor, which is sometimes enormous, and the thinness of its walls, and nothing else, suggest the use of the bistoury and the evacuation of the fluid. The result in such cases of practicing the purest expectation so far as the abscess is concerned is that the integument becomes gradually exceedingly thin at one point and at length ruptures with collapse of the tumor and a slight purulent discharge for a longer or shorter time, with finally an unimportant scar more or less deeply attached to the fascia and perhaps, also, to the bone beneath. As a rule, the sac opens unexpectedly while the child is at play. In two of my cases the opening occurred during sleep, and the child supposed in the morning that he had wet the bed. The entire history of such an abscess after the fluctuating tumor is recognized is free from pain. It does not impair the patient's health in the slightest degree, and it has no appreciable bad effect on the progress of the bone disease toward recovery or on the condition in which recovery

leaves the patient. There is nothing to suggest operative interference except adherence to the old rule.

There are, however, cases in which abscesses follow a widely different course. Instead of a painless we have a painful tumor, hot and red. The limb may be greatly swollen, but by an infiltration rather than a collection of fluid. The skin is tense and brawny. The patient is kept awake by pain, has no appetite, and wastes away. He keeps his bed, insisting on the maintenance of traction. After a while the tumor points and opens with diminution of pain and improvement for a time in the general condition. But pus gathers again and opens at another point with a repetition of the pain and prostration, and this occurs again and again, until there may be a number of sinuses on all sides of the thigh and hip. It is difficult to conceive of a surgical case more sure to give the medical attendant anxiety and more suggestive of the necessity of resorting to heroic measures. It is not strange that a similar condition in the knee made amputation a few years ago, and later excision, the routine treatment. I have treated, as doubtless others of us have, a number of such cases, both in the hip and the knee, as well as in the ankle, without interfering with the natural course of the abscesses, but with unremitting attention to the mechanical and hygienic requirements of the case, and have had no reason to regret the result, except so far as I have thus put myself out of harmony with prevailing surgical opinion—I mean the opinion prevailing among general surgeons—which still commends rapid and strenuous procedures in these cases. I have no desire to willfully oppose accepted views, but am impelled by the favorable results of experience to state that my practice in these difficult cases is: (1) to give the bone and joint the most absolute mechanical rest possible; (2) to insist on the most liberal and varied diet, of which, as a rule, milk in unlimited quantities

is the staple; and (3) to permit the use of opium, which, if used, is to be given in potent doses.

I should not omit to give my reasons for failing to see the importance of incision, scraping, and antiseptic closure of the abscesses in question. Incision is a tardy and fruitless procedure. The most painful stage in the history of the abscess is long past. It was present when the pus was collecting under the periosteum and in the cells of bone. If we could interfere early with the bistoury and knew where to direct its point, we might relieve the pain, and perhaps, in favorable circumstances, shorten the case and save bony tissue by dividing the thickened periosteum or breaking the shell of compact bone. But when the pus is in the cellular structures or the cavity of the joint, I do not see that the progress of the case can be materially affected by interference. If the abscess is cold, there is no painful tension to be relieved. If it is phlegmonous, tension is the result of inflammatory infiltration and can be relieved only by extensive and multiple incisions. If we operate in either case we substitute artificial for natural closure, and with the best antisepsis we gain nothing by operating unless we reach and scrape out the purulent depot or the interior of the joint, and then nothing unless we remove the eroded cartilage and exfoliating bone and excavate the focus, and then nothing in many cases unless we remove large quantities of bone or excise the joint. And if we operate in the manner described we do not avoid the necessity of bringing to bear the best mechanical treatment and hygienic control, which, if they are supplied, will bring about a recovery, whether we operate or not, by the slow but sure process of natural repair, with the better result the less we interfere with the soft parts, as a general rule.

I would not be understood to assign no value to the use of the knife in exceptional cases, but simply to hold the

opinion that in the management of the majority of the abscesses of hip disease operative interference is useless.

It is not agreeable to make distinctions and to divide one's fellow-practitioners into classes, but, as was pointed out by Dr. Ketch in the discussion of last May, above referred to, it does not take much observation of the way in which the abscesses of hip disease are treated at the present time to see that the general surgeon, whose reliance is chiefly on operative procedures, resorts to the knife with the hope of promoting a rapid recovery, while the orthopædic surgeon, whose reliance is chiefly on mechanical means, seeing that the case, no matter how treated, will be long and tedious, devotes himself to the proper management of the bone disease, and thinks but lightly of the incidental abscesses.

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